UPDATE
Healthy Families Program Transition to Medi-Cal
Strategic Plan/Phase 1 Implementation Plan
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Overview

Assembly Bill (AB) 1494, Chapter 28, Statutes of 2012, provides for the transition of approximately 863,000 Healthy Families Program (Healthy Families) subscribers to the Medi-Cal Program beginning January 1, 2013, in four Phases throughout 2013. The Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), and the Department of Managed Health Care's (DMHC) focus is to work collaboratively to facilitate a smooth transition, minimize disruption in access to services, maintain existing eligibility gateways, and maintain access to and continuity of care.

This submission fulfills the Legislative requirement to submit the Phase 1 network adequacy assessment to the Legislature at least 60 days prior to the start of Phase 1, pursuant to Welfare and Institutions Code Section 14005.27 (e)(9). It also serves to update the Strategic Plan/Phase 1 Implementation Plan that was provided to the Legislature October 2, 2012, as described in the Plan's accompanying cover letter. It provides more specific details about the State's ongoing efforts to prepare for and implement Phase 1 beginning January 1, 2013.

Phase 1 Transition Details

Health Care and Vision Coverage

In Phase 1, Parts A and B, approximately 400,000 children will transition from the Healthy Families Program to Medi-Cal (see Tables A and B). In response to stakeholder input and the need for flexibility, Phase 1 will occur in two separate sub-phases: in Part A, children will transition to Medi-Cal effective January 1, 2013, and in Part B, children will transition on March 1, 2013. The Phase 1 transition is specific to children that are enrolled in a Healthy Families health plan that is also a Medi-Cal managed care health plan.

The counties were placed in Parts A and B based on: having representation of each Medi-Cal managed care plan model—Two-Plan, County Organized Health System, and Geographic Managed Care—findings from the network adequacy assessment demonstrating a significant overlap in providers for health plans and working with a smaller group of counties to be able to appropriately identify and address any unanticipated issues that may arise to further ensure a smooth transition for children who are in Part B.

In terms of vision coverage, today in the Healthy Families Program, children receive vision services through a separate vision plan. In Medi-Cal, while the benefits are nearly identical, vision services will be available as part of the medical coverage that is provided through the managed care health plan and will be provided based on medical necessity criteria including Early Periodic Diagnosis Screening and Treatment (EPDST) services, as applicable. Once the child transitions, the Medi-Cal managed care plan will mail informing materials to them which include a Member Handbook, Provider Directory, Evidence of Coverage (EOC) and a health plan card. The Provider Directory explains the process to the member on how they can choose a Primary Care Provider (PCP).

Table A—Counties Transitioning in Phase 1, Part A, on January 1, 2013

Counties Transitioning on January 1, 2013		
County	**Health Plan**	**Enrollment**
Alameda	Alameda Alliance for Health	10,177
	Anthem Blue Cross	805
Riverside	Inland Empire Health Plan	31,803
	Molina Healthcare	5,395
San Bernardino	Inland Empire Health Plan	24,994
	Molina Healthcare	4,392
San Francisco	San Francisco Health Plan	7,166
	Anthem Blue Cross	221
Santa Clara	Santa Clara Family Health	16,934
	Anthem Blue Cross	4,670
Orange	CalOptima	35,983
San Mateo	Health Plan of San Mateo	6,028
San Diego	Community Health Group	23,824
	Kaiser	11,967
	Molina Healthcare	13,606

Table B—Counties Transitioning in Phase 1, Part B, on March 1, 2013

Counties Transitioning on March 1, 2013		
County	**Health Plan**	**Enrollment**
Contra Costa	Contra Costa Health Plan	4,752
	Anthem Blue Cross	606
Fresno	CalViva Health	13,351
	Anthem Blue Cross	1,350
Kern	Kern Family Health	10,669
	Heath Net	5,056
Kings	CalViva Health	541
	Anthem Blue Cross	2,966
Los Angeles	LA Care	11,323
	Health Net	56,856
Madera	CalViva Health	853
	Anthem Blue Cross	2,573
Tulare	Anthem Blue Cross	9,097
	Health Net	3,026
Sacramento	Anthem Blue Cross	1,386
	Health Net	11,075
	Kaiser Foundation	13,568
	Molina Healthcare	1,449
San Diego	Health Net	10,411
Napa	Partnership Health Plan of CA	138
Solano		859
Sonoma		528
Yolo		820
Monterey	Central California Alliance for Health	18,856
Santa Cruz		4,831
Santa Barbara	CenCal	7,764
San Luis Obispo		1,421

Dental Coverage

Dental services will transition at the same time as the medical coverage transitions based on the phase-in schedule. The mode of dental coverage delivery is determined by the child's county of residence. All children, except those residing in Los Angeles and Sacramento Counties, will be provided dental services under Denti-Cal which is Medi-Cal's fee-for-service dental program delivery system.

- Phase 1, Part A—Since neither Sacramento nor Los Angeles are in Phase 1, Part A, all children transitioning on January 1, 2013, will transition from Healthy Families Program dental managed care plans to Denti-Cal.
- Phase 1, Part B—In Phase 1, Part B, all children except those residing in Sacramento and Los Angeles will transition from Healthy Families Program dental managed care to Denti-Cal.
    - Sacramento County—Children in Sacramento County will transition into a Medi-Cal dental managed care plan. If a child's Healthy Families Program dental plan is a Medi-Cal dental managed care plan, the child will automatically enroll into that plan. If a child's Healthy Families Program dental plan is not a Medi-Cal dental managed care plan, the child will automatically be enrolled into a plan where their primary care dentist is an in-network provider.
    - Los Angeles County—Children in Los Angeles County enrolled in a Medi-Cal dental managed care plan will be enrolled into the same dental plan if the Healthy Families Program dental plan is also a Medi-Cal dental managed care plan. If the child's Healthy Families Program dental plan is not a Medi-Cal dental managed care plan, the child will be enrolled into Denti-Cal fee-for-service.

Table C—Dental Managed Care Plans in Phase 1, Part B

County	**Plan**
Los Angeles	Access Dental
	Care 1st Dental
	Health Net
	LIBERTY Dental
	SafeGuard Health
	Western Dental Services
Sacramento	Access Dental
	Health Net
	LIBERTY Dental

For children who will be receiving their services under the Denti-Cal program who will need to find a provider, the following steps will occur:

Children who will be receiving their services under the Denti-Cal program can locate a provider by calling Denti-Cal's Beneficiary Customer Service line or searching the Denti-

Cal website to locate providers that are accepting new patients. Both of these touch points for beneficiaries are currently being improved to ensure ease of accessing providers and care.

DHCS is currently working to improve the referral process with regard to the Beneficiary Customer Service line in order to warm transfer beneficiaries to a dental provider who has actively indicated to the representative they are accepting new patients. In addition, the list of providers who are accepting new patients online is being improved to add ease for a provider to be added. In updating these processes for the online listing, beneficiaries will have a wider selection of providers in their area from which to choose. In addition to the list of providers accepting new patients online, DHCS is working with the Centers for Medicare and Medicaid Services (CMS) to add a link to the insurekidsnow.gov website in which Denti-Cal sends the entire network. The website offers the feature of searching providers by State, program, name of provider, location of beneficiary, specialty, accepting new patients, and other factors.

For children who will be receiving their services in a dental managed care plan, they will be sent a Welcome Packet from their dental plan which will include information about the dental plan, an evidence of coverage (including benefits), and a member identification card including information about their assigned provider. If a beneficiary has questions about their dental plan, provider, benefits or anything else related to dental they should call their dental plan member services line. The member services lines for each dental plan is listed online and the web address will be listed on the Confirmation Letter sent to beneficiaries prior to their transition.

Behavioral Health Services

Access to behavioral health services, including mental health and substance use treatment services, are critical to the well-being of children who need such services. The State is committed to working with families, providers, counties, plans, and regional centers to facilitate communication amongst the parties listed in order to connect children to the services they need and to provide care continuity throughout the transition.

DHCS, through MRMIB, has requested data from Healthy Families plans on specific information about the utilization of mental health and substance use disorder treatment services within Healthy Families (Attachments K and M). DHCS will use this data to facilitate care continuity for children receiving these services.

The California Health and Human Services Agency (Agency) has convened a Behavioral Health Workgroup to work with counties, stakeholders, the departments, and MRMIB, on best practices to transition children smoothly with behavioral health needs from the Healthy Families Program delivery systems to the Medi-Cal delivery systems.

Mental Health Services

Healthy Families currently provides “basic” mental health services, as described in California Code of Regulations (CCR), Title 10, Chapter 5.8, §2699.6700. These services are provided by the child’s primary care physician (PCP), or by another mental health specialist that is part of the Healthy Families health plan provider network. If a child is thought to be seriously emotionally disturbed (SED), per Welfare and Institutions Code Section 5600.3, the Healthy Families subscriber is referred to his or her local county mental health department for an SED assessment. If the mental health department determines that the child meets the SED criteria, it assumes responsibility for the provision of care to treat and payment of nearly all treatment for the SED condition(s).

Children in the Medi-Cal program are eligible to receive the full range of Medi-Cal/EPSDT mental health services, and their specific mental health needs will determine how they will receive such services. Medi-Cal managed care plans cover only the mental health services that can be provided by the child’s PCP within the PCP’s scope of practice. If the child’s needs exceed this level of service, the Medi-Cal managed care plan will either 1) refer them to a Medi-Cal fee-for-service provider outside of the managed care plan’s provider network; or, 2) refer them to the county mental health plan if the Medi-Cal managed care plan believes that the child meets the medical necessity criteria to obtain specialty mental health services. The county mental health plans are required to ensure that each beneficiary that meets medical necessity criteria for Medi-Cal specialty mental health services has access to a provider.

Alcohol and Drug Treatment Services

Substance use disorder (SUD) treatment is a covered Medi-Cal benefit through the Drug Medi-Cal (DMC) program. Counties to which this program was realigned in July 2011 administer DMC services directly and/or through subcontracted providers. DMC services include individual and group counseling, typically in an outpatient setting, and for persons who are pregnant or in the postpartum period, services may be provided in a residential setting.

Per the MRMIB 2010 report on Behavioral Health, less than one percent of Healthy Families beneficiaries access SUD services. For those Healthy Families patients currently receiving SUD treatment, the department is requesting county by county information from the Healthy Families network to determine the number of and treatment location for the patients, and will coordinate with county Alcohol and Drug Administrators to coordinate patient referrals and ongoing care.

Services for Children with Developmental Disabilities

The Department of Developmental Services (DDS) provides services to over 250,000 California’s children and adults with developmental disabilities that begin before an individual reaches adulthood. Eligibility is based on level of disability, not on income or Medi-Cal linkage. These disabilities include mental retardation, cerebral palsy, epilepsy, and autism and related disabling conditions. Services are primarily provided through DDS’ network of 21 not-for-profit regional centers.

Specific to this transition, stakeholders raised questions targeted around behavioral health services utilized by children with autism or pervasive developmental disorder. In Healthy Families, children receive these services through their health plans, although a small number, approximately 300 – 400 children, receive services through DDS' regional centers. In Medi-Cal, health plans do not arrange and pay for these services; instead, DDS-eligible children are served through the regional centers.

The State will facilitate further discussions on these services with plans, regional centers, and other stakeholders through its Behavioral Health Workgroup and will work with the workgroup members to develop strategies to communicate this change in delivery system to children and their families.

California Children's Services

The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

Currently, approximately 75 percent of the CCS caseload are Medi-Cal beneficiaries; 15 percent are Healthy Families subscribers; and 10 percent are CCS-only, with no Medi-Cal or Healthy Families eligibility linkage. In both Healthy Families and Medi-Cal, CCS services are generally "carved out" of the health plans' responsibility, meaning that the health plan does not have financial responsibility for paying for or managing these services. In Medi-Cal, there are 3 County Organized Health Systems that have CCS "carved-in:" Health Plan of San Mateo, CenCal Health Plan, and Partnership Health Plan.

In addition, with regard to dental orthodontics, beneficiaries who are receiving orthodontics in Healthy Families will be able to continue receiving this care through the Denti-Cal program. Currently in the Healthy Families program, beneficiaries receive their dental orthodontic care with CCS through the Denti-Cal program, who adjudicates prior authorizations and claims. Therefore, the orthodontics received in Healthy Families is provided by a Denti-Cal orthodontist and Healthy Families beneficiaries will not be affected.

Vaccines for Children Program

The Vaccines for Children Program (VFC) provides free vaccines to doctors who serve eligible children 0 through 18 years of age. Medi-Cal children are eligible children. The VFC program is administered at the national level by the US Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases and by the California Department of Public Health (CDPH), Immunizations Branch at the state level. CDC contracts with vaccine manufacturers to

buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccines through their state VFC Program and receive routine vaccines at no cost. This allows them to provide routine immunizations to eligible children without high out-of-pocket costs.

DHCS will continue to work with CDPH on VFC to advise that the Healthy Families providers that are not already Medi-Cal managed care providers are aware of what they need to do to become VFC providers. In order to access VFC, providers do not need to enroll to become Medi-Cal providers, but they do need to become VFC providers through CDPH.

The enrollment process typically takes 4-6 weeks, but CDPH would work expedite the process for providers that have patients that are transitioning if a provider's enrollment comes up against the transition date. CDPH staff have participated in and presented information on VFC at two of the three stakeholder webinars held this Fall in order to help facilitate provider enrollment.

Provider lists have been provided to the VFC staff to cross reference with their provider master file to help target outreach strategies and provider education on how to enroll in the program for those providers who are not currently enrolled. Given the significant overlap of providers as identified by the network adequacy assessment, it is expected that many of these providers are already enrolled VFC providers.

Communication with Children and their Families

Notifying children and their families of the transition is critical to facilitating a smooth transition. Statute requires that the State provide written notice to transitioning children 1) at least 60 days prior to the start of Phase 1, and 2) at least 90 days prior to the start of Phases 2 through 4. Stakeholders and the State's federal partners at the Centers for Medicare and Medicaid Services (CMS) have had and will continue to have the opportunity to comment on all notices to children and their families and the State will consider their comments prior to finalization of the notices.

Notices to Children and their Families

For Phase 1, Part A, children and their families will receive 2 notices prior to their transition date, January 1, 2013, including a Welcome Packet—1) DHCS sent out a notice targeted for November 1, 2012, meeting the 60-day statutory requirement, that reminds children and families that transitioning children have coverage throughout their transition, informs families that their child's health plan will not change, and provides Frequently Asked Questions and answers, 2) DHCS will send out a personalized reminder notice in early December; the notice will explicitly state the child's transition date and provide more detailed information on the changes in delivery systems—particularly dental, vision, and behavioral health services. The December reminder notice mailing will also contain a Welcome Packet. It will include general Medi-Cal

informing materials such as general eligibility, covered services, fair hearings, rights and responsibilities and continuity-of-care rights, and what to do if a family has a problem accessing care. All mailings will be translated into the 12 Medi-Cal threshold languages and provide contact information for resources to answer questions and provide additional assistance. Please see Attachments H and J—the General Notice and the Phase 1, Part A, November 1, 2012, notice, respectively.

Phase 1, Part B, children will receive notice at least 60 days prior to March 1, 2013, a reminder approximately 30 days prior to the transition date, and a Welcome Packet, as described above, as part of the reminder notice mailing. They will also receive a General Notice—to be mailed by MRMIB in early November.

In addition to the Welcome Package, a Beneficiary Identification Card (BIC) will be mailed separately to each beneficiary along with instructions on how to use the card. They will also receive a new card from their health plan and other plan information immediately after they are transitioned into Medi-Cal.

Consumer Assistance

The State anticipates increased use of available call centers as the transition gets underway. Both the General Notice and the November 1, 2012, notice direct Healthy Families Program children and their families to call the Healthy Families Program with questions. Once these children transition to Medi-Cal, beginning January 1, 2013, DHCS expects increased call volume to the DHCS Medi-Cal Managed Care Ombudsman and Health Care Options call centers with questions about how a child can access their Medi-Cal benefits and how a child can change their health and dental plans. MRMIB, DHCS, and DMHC are coordinating call center scripts to provide accurate and consistent responses to questions.

Additionally, the Phase 1, Part A, notice recommends that families also call their health plan for more detailed information, such as answering the questions “will I be able to keep my primary care provider”? While the DMHC and DHCS network adequacy report shows significant provider network overlap, only the plan may answer that question with certainty.

Medi-Cal managed care plans will provide referral assistance to children needing mental health or alcohol and drug treatment services. Children in need of specialty mental health services are automatically enrolled in county mental health plans and in many cases children with this level of need are already receiving services from the plans under the Healthy Families Program; however, staff of the DHCS Mental Health Services Ombudsman Unit will be prepared to address the possibility of calls coming from families seeking services for their children. DHCS will work with county alcohol and drug programs to develop a strategy for referring families seeking to directly contact local programs to obtain alcohol and drug treatment services for their children.

The State is also actively engaged with a variety of stakeholders that represent on-the-ground, community-based assistance groups. These include certified application assisters to legal aid resources to county health and human services offices. The State holds regular planning group meetings and Webinars to provide information to stakeholders and to dialogue about the transition and what families and advocates are experiencing. The State will continue to convene these forums throughout the transition in order to facilitate discussions about how to communicate with families, plans, providers, and community-based assistance organizations.

Network Adequacy Assessment

Background

The Department of Managed Health Care (DMHC) licenses and regulates health plans pursuant to the Knox-Keene Health Care Services Plan Act of 1975, as amended ("Knox-Keene Act"). MRMIB contracts with health plans licensed by the DMHC to provide coverage for Healthy Families subscribers. Therefore, throughout the transition required by AB 1494, DHCS, MRMIB, and the DMHC's main focus will be to work collaboratively to facilitate a smooth transition, minimize disruption in services, maintain existing eligibility gateways, and confirm access to and continuity of care.

Prior to each Phase, DHCS, in consultation with DMHC (the departments), will assess each plan provider network and ensure that Plans meet the network adequacy requirements necessary for a smooth transition. It is the goal of the departments that children's care is not affected by the transition.

The attached Network Adequacy Assessment Report is specific to health and dental plans and Denti-Cal in Phase 1, Parts A and B. The departments will conduct similar, separate, assessments for each subsequent Phase. For Phase 1, Parts A and B, DHCS and DMHC jointly submitted a request to all medical and dental Medi-Cal managed care plans participating in Phase 1 to provide data related to their networks and performed a thorough analysis.

For purposes of transition planning for Medi-Cal's fee-for-service dental system, DHCS undertook an extensive process to analyze the impact of the Healthy Families transition on the Denti-Cal program services and provider networks and identified key strategies to employ to ensure network adequacy. It is estimated that of the 863,000 children who will transition to Medi-Cal, approximately two-thirds of them will receive services under the Denti-Cal program. Based on these efforts, the data indicates 82 percent of Healthy Families dental providers are also enrolled in Denti-Cal and a recent survey of Healthy Families providers indicates that 92.1 percent of the Healthy Families Program children will continue to receive care from their same dental provider post-transition. In terms of capacity, there will be no less than one provider per every 903 beneficiaries for all counties in Phase 1. Denti-Cal will hold a series of webinars to educate providers on how to enroll in the Denti-Cal program, how to bill for services, and to answer other

questions. Denti-Cal will publish bulletins monthly to educate providers on program changes.

DHCS, along with DMHC, will monitor the networks throughout the transition through several mechanisms. Beginning February 15, 2013, and monthly thereafter, for the duration of the transition, DHCS must report to the Legislature information on health plan grievances related to access to care, continuity of care requests and outcomes, changes to provider networks, including provider enrollment and disenrollment changes, and eligibility performance standards. DHCS and DMHC will request this information from plans and counties as necessary in order to compile the monthly reports. Additionally, a final comprehensive report must be provided within 90 days after completion of the last phase of transition.

Also, DHCS will contact health plans when concerns about network adequacy are presented either by the data submitted by the plans or by stakeholder and provider feedback. The plan will be notified of the concern and will be asked to submit to the departments its plan of action for rectifying the situation. Ongoing monitoring and follow up with the plans will continue to facilitate a seamless transition and continuity of care both during and after the transition. DHCS engages in weekly calls with their managed care health plans specific to the Healthy Families transition and holds quarterly Advisory Group meetings to discuss such topics as the Healthy Families transition.

Summary of the Phase 1 Network Adequacy Assessment

AB 1494[1] requires that DHCS and DMHC collaborate in assessing Medi-Cal managed care plan network adequacy for that transition. The departments reviewed the networks for all full-service and dental Medi-Cal managed care plans scheduled to transition during Phase 1 and have individually assessed each health plan's network.[2]

The departments evaluated the health plan networks against established Knox- Keene Act network and access standards and standards set forth in the DHCS health plan contracts. DHCS took the lead in evaluating for DHCS contractual requirements and DMHC took lead responsibility for evaluating for Knox-Keene Act compliance.

The DMHC and DHCS standards include:

- One primary care provider (PCP) within 10 miles or 30 minutes of a member's residence.
- One PCP for every 2000 enrollees
- One physician (including specialists) for every 1200 enrollees
- No more than one full-time equivalent physician extender per 1,000 enrollees

[1] California Welfare and Institutions Code section 14005.27(e)(9)(A) requires this collaboration in order to assess health plan network adequacy for each of the four Phases.
[2] Even though the Phase 1 transition has been separated into two sub-phases, the network adequacy review was conducted for all plans that meet the Phase 1 criteria.

- A PCP may supervise a maximum of two physician assistants, four nurse practitioners, or any combination of four physician extenders that does not include more than three certified nurse midwives or two physician assistants.
- Readily available and accessible medically required specialists.

The departments jointly submitted a request to all Medi-Cal managed care plans participating in Phase 1 to provide data related to their provider networks and data relevant to the plan network adequacy assessment, as described in the above criteria. The request for information went out to full service plans on August 31, 2012, and they were instructed to file their response with the DMHC on September 14, 2012. The DMHC provided DHCS access to the information contained in the filing. This request was also submitted to all dental managed care plans participating in the Medi-Cal program on September 6, 2012, and they were instructed to similarly file their response with the DMHC on September 14, 2012. The data request templates sent to all health and dental plans are included in this report (Attachments B, C, D, E, F, G). The following describes the types of data the departments requested and how the DMHC used the data to evaluate the impact of the Healthy Families transition on Medi-Cal managed health care provider networks.

Availability and Capacity of Providers—Quantitative Data

Full-Service Health Plans

The departments coordinated a request of quantitative data from those health plans involved in the Phase 1 transition, related to their Medi-Cal and Healthy Families networks. These requests focused on identifying the number of PCPs, physician extenders[3], and specialists in each plan's Healthy Families and Medi-Cal networks for each county in which the plans operate these lines of business. For PCPs, questions focused on the capacity of these providers to serve new Medi-Cal enrollees, how many enrollees are currently assigned to them, identifying which providers will continue to see Healthy Families subscribers post-transition, and the geographic location of the providers. For specialists, the request focused on the specialty types available in each network, what the utilization of each specialty type has been for the past year, the number of specialists available in each specialty area, and how many of those specialists have a pediatric practice for Healthy Families and Medi-Cal.

Dental Plans

The departments coordinated a request of similar quantitative data for all dental managed care plans operating in the two dental managed care counties: Sacramento and Los Angeles. The request focused on primary care dentists (PCDs) and dental specialists. For PCDs, the questions focused on the capacity of these providers, how many members are currently assigned to them, and identifying which providers will continue to see Healthy Families subscribers post-transition. For specialists, the request

[3] A physician extender is a non-physician health care professional (i.e. nurse practitioner, midwife, physician assistant) that is supervised by a physician and extends the physician's ability treat additional patients.

focused on what specialty types are available in each network, the utilization of each specialty type over the past year, the number of specialists available in each specialty area, and how many of those specialists have a pediatric practice for Healthy Families and Medi-Cal.

Continuity of Care, Timely Access, and Plan Readiness—Qualitative Data

The goal of the transition is to facilitate a smooth transition for children. With that goal in mind, the departments also requested qualitative data from each full-service and dental plan involved in the Phase 1 transition. These plans were asked to provide detailed responses to questions regarding how the plans will: 1) prevent disruptions in services to patients, 2) ensure timely access to services, 3) ensure its administrative staff is prepared for the transition, and, 4) make efforts to incorporate their Healthy Families providers into the Medi-Cal program. The full-service health plans were asked to provide a detailed response to questions regarding how they will provide continuity of care, communicate with members about the transition, and address out-of-network requests.

Ongoing Monitoring, Data Collection and Reporting, and Performance Standards

Eligibility data reports will be reported monthly and posted on the DHCS website. DHCS will monitor specified performance standards, including, as required by the enacting legislation, Welfare and Institutions Code, section 14005.27 (n)(2) and 14154 (d). The performance standards will be reported on a semi-annual basis and posted on the DHCS website.

Analysis

For the health plans covering medical services, the focus of the network adequacy assessment was on the primary care provider and specialist overlap between the Healthy Families and Medi-Cal networks, the capacity of the Medi-Cal network to absorb additional enrollment, and how each health plan will provide continuity of care for enrollees that are in the middle of receiving services during the transition.

DMHC and DHCS reviewed the data, utilizing staff from both departments to comprise one review team. For each Phase 1 health and dental managed care plan, the team separately reviewed the plan's Healthy Families and Medi-Cal networks in each Phase 1 county in which it operates. The departments' analysis is based on data provided by the plans between September 14, 2012, and October 12, 2012. In addition, since the data reflects the provider networks as they existed in September 2012, those networks are expected to continue to develop and expand through and after January 2013. Many plans have indicated they are in the process of negotiating new Medi-Cal contracts and are actively working to bring more providers into their networks. Therefore, the departments, in coordination with the plans, will continue monitoring the plans' networks after Phase 1 of the transition has been completed.

Conclusion

The departments conclude that there is a high degree of overlap between the Healthy Families and Medi-Cal networks and that health plans, dental plans, and Denti-Cal have the provider capacity and network adequacy to proceed with the transition of Phase 1, Part A, children to Medi-Cal on January 1, 2013. The health plans generally have sufficient capacity to handle the transition related enrollment and have capacity to handle new enrollment as new applicants enter into the Medi-Cal program. Each plan has also indicated that it will provide continuity of care consistent with the requirements of the Knox-Keene Act.

Due to concerns with Health Net's network, Health Net in San Diego will transition in Part B, not in Part A, as previously announced on October 23, 2012. However, enrollees in San Diego's three other plans, Community Health Group, Kaiser, and Molina Healthcare, will transition in Part A, as scheduled. To date, it appears that Health Net has a low percentage of overlap between its Healthy Families and Medi-Cal networks. Many Health Net Healthy Families PCPs do not know if they will continue to treat the transitioning enrollees. The Health Net enrollment will be transitioned during the March 1, 2013, Part B of Phase 1. Prior to the transition of enrollees March 1, 2013, Health Net will need to provide updated data so that the departments can reassess Health Net's network.

CalViva is a local initiative plan operating in Fresno, Kings, and Madera counties. CalViva has an administrative services agreement with Health Net whereby Health Net administers all health care services for CalViva, and CalViva uses Health Net's Medi-Cal provider network. Cal Viva will need to provide updated data so the departments can reassess its respective Healthy Families and Medi-Cal networks for these counties.

The departments also identified network concerns with the Anthem Blue Cross provider network in Tulare County. In Tulare County, Anthem provides Healthy Families coverage through an Exclusive Provider Organization[4] (EPO), which does not require enrollees to be assigned to PCPs. Instead, enrollees can seek services from any contracted PCP. Additionally, the PCP overlap between Anthem's Healthy Families network and the Medi-Cal network in Tulare County is relatively low. Therefore, it is difficult to determine whether the transitioning enrollees will be able to maintain their PCPs post-transition. In other counties where Anthem uses an EPO product, there is greater overlap between the Healthy Families and Medi-Cal networks. In those counties, the likelihood of Healthy Families enrollees being able to keep their PCP is significantly higher. Anthem Blue Cross' Healthy Families enrollment in Tulare County is scheduled to transition no earlier than March 1, 2013. Anthem Blue Cross will need to address the departments' concerns before it will be able to transition its Tulare County Healthy Families enrollees into Medi-Cal managed care.

[4] An Exclusive Provider Organization (EPO) does not reimburse for out-of-network services. Although a patient may obtain care outside of the EPO network, no coverage will be provided for those services and the patient will be responsible to pay for the full costs of services received.

Transition Preparation Activities

Stakeholder Engagement

Effective, ongoing communication is critical to the success of this transition. Such communication must involve the engagement of key partners including the federal CMS, other state agencies/ departments, the Legislature, health and dental managed care plans, and advocates. Key state agencies/departments engaged with DHCS are MRMIB, Agency, DMHC, and the Department of Finance.

The Strategic Plan/Phase 1 Implementation Plan describes ongoing stakeholder engagement efforts. Since its release, in response to stakeholder input and testimony at the October 16, 2012, Joint Hearing of the Senate Budget and Fiscal Review and Health Committees, the State has established a Behavioral Health Services Workgroup. It will provide a forum in which state and federal officials, stakeholders, counties, plans, and providers may discuss and share best practices for the facilitation of continuity of care for children in need of behavioral health services, including mental health services, alcohol and substance use treatment services, and services for children with autism and pervasive developmental disorder.

Functions to be Maintained from Healthy Families Program in Medi-Cal

DHCS will contract with MAXIMUS, the Healthy Families administrative vendor, for ongoing work associated the transition. The anticipated scope of work activities include maintaining the Single Point of Entry (SPE), managing premium payments, maintaining call center operations, developing needed systems changes for interfaces with the county eligibility systems and MEDS, and developing changes to the Health-e-App web portal. In using the SPE, MAXIMUS will continue to provide Accelerated Enrollment for children. The purpose of Accelerated Enrollment is to assign temporary, fee-for-service, full-scope, no-cost Medi-Cal enrollment for children under the age of 19 who are new to Medi-Cal, applied for Medi-Cal through SPE, and are likely eligible for a Medi-Cal percent of poverty program[5] based on the screening done at SPE.

DHCS plans to maintain the same premium payment collection processes and standards as Healthy Families, adjusting as needed to conform to Medicaid requirements, and plans to contract with MAXIMUS for premium collection management. Families will be able to use the same payment methods available to subscribers in Healthy Families, including, checks, money orders, cash to any Western Union Convenience Pay location, credit card over the phone or the website, electronic fund transfers with the 25 percent monthly discount or paying 3 months of premiums in advance and getting the 4th month free.

As DHCS' vendor, MAXIMUS will be responsible for sending monthly premium billing notices, premium collections, notices of lack of payments, and notification to counties,

[5] DHCS is working through the policy of determining the applicable FPL income level that can be used for accelerated enrollment and will obtain guidance from CMS on this matter.

when there is a lack of payment two consecutive months, to initiate a redetermination of Medi-Cal eligibility. DHCS will employ the use of Express Lane Eligibility (ELE) for transitioning cases and will continue to use Accelerated Enrollment for new cases.

Eligibility and Enrollment Process

DHCS has responsibility for establishing policies and procedures for eligibility determination processes, premium collection and cost sharing provisions and performance metrics for application processing. DHCS will work closely with counties, MAXIMUS, the Healthy Families Administrative Vendor, and stakeholders on these efforts.

County Administration Readiness
In preparation for the start of Phase 1, Part A, DHCS has led technical stakeholder meetings with counties, including the County Welfare Directors' Association (CWDA), to detail out the operational changes needed to transition the children.

DHCS will release several All County Welfare Director's Letters (ACWDLs) (Attachments A and O) regarding the transition. Draft letters will be shared with counties, stakeholders, and CMS to obtain feedback prior to being finalized and released by DHCS. The first letter is about the Healthy Families Transition to Medi-Cal which focuses on the policy for transitioning children currently covered by Healthy Families. The second letter is about the new coverage group, Targeted Low-Income Children's Program, which focuses on the policy for increasing the FPL limits for children ages zero to 19 and the use of aid codes for these children. The third letter will be a technical letter to the counties about how the county eligibility systems will interact and interface with MAXIMUS and the Medi-Cal Eligibility Data System (MEDS). It is anticipated that these letters will be finalized in November 2012.

For purposes of the transitioned cases, DHCS will accept the most current eligibility determination made by MRMIB/MAXIMUS to transition the Healthy Families child to the applicable new Medi-Cal transition aid code. The child's annual redetermination date will remain the same as it was under Healthy Families. DHCS also will continue to use Accelerated Enrollment for new cases that present at the SPE in accordance with existing Medi-Cal policy.

Eligibility Data Reports and Performance Standards

DHCS has convened five conference calls with the counties, the County Welfare Director's Association, the consortia, and other interested stakeholders to discuss the required data reports and performance standards. Follow-up conference calls were scheduled, as needed, in October 2012 to finalize the requirements for the data reports and performance standards.

The data reports will include information on the number of applications processed on a monthly basis, a breakout of the applications based on income using the FPLs, the final

disposition of each application, including information on the approved Medi-Cal program, if applicable, and the average number of days it took to make the final eligibility determination for applications submitted directly to the county and from SPE. These data reports will be reported monthly and will be made public each month by posting on the DHCS website. The required performance standards will be in accordance with Welfare and Institutions Code, sections 14005.27 (n)(2) and 14154 (d), which requires the counties to process applications for children who are granted AE by the SPE or who are not granted AE by the SPE due to the existence of an already active Medi-Cal case within 45 days. The Performance Standards also require the counties to process ninety percent of applications received from SPE, which are complete and without client errors, within 10 working days of receipt. The performance standards will be reported on a semi-annual basis and will be publicly reported and posted on the DHCS website.

Premium Management

DHCS plans to maintain the same premium payment collection processes and standards as Healthy Families, adjusting as needed to conform to Medicaid requirements. Families with incomes above 150 percent of the FPL and up and including 250 percent of the FPL will be subject to premiums - $13 monthly for each child, with a maximum of $39 monthly per family.

DHCS intends to contract with MAXIMUS for premium collection management services including providing informational services that instruct families on how and where to pay premiums. Families will be able to use the same payment methods available to subscribers in Healthy Families - use of checks, money orders, cash to any Western Union Convenience Pay location, by credit card over the phone or on the website, or by electronic fund transfers with the 25 percent monthly discount, or by paying 3 months in advance and getting the 4th month free. MAXIMUS will be responsible for sending monthly premium billing notices (to be paid by the 20th of each month), premium collections, notices for lack of payment, and notification to counties for when there is a lack of payment for two consecutive months to initiate a redetermination of Medi-Cal eligibility.

Counties will conduct a redetermination of Medi-Cal eligibility consistent with the process set forth in Senate Bill (SB) 87 (Escutia, Statutes of 2000, Chapter 1088) during which time the child will continue to receive benefits. Under SB 87, the county must follow three specific steps to determine eligibility: 1) a thorough ex parte review; 2) phone contact if necessary, and, finally, 3) sending a special form for information if necessary. The county must evaluate the case for continuing eligibility under another Medi-Cal program. If the child is not eligible for any other program, the county would discontinue the case for no premium payment and would provide a timely Notice of Action which would provide hearing rights and information on how to request a fair hearing. The counties will notify MAXIMUS if upon completion of the reevaluation the child is found to be eligible for another program, ineligible for any Medi-Cal program, or if the family requests to disenroll the child. Upon notification from counties of the child's

disenrollment from the program, MAXIMUS will be responsible for discontinuing premium collection services.

Cost Sharing (Premiums and Co-Payments)

Currently Medi-Cal has nominal co-payment requirements pursuant to Welfare and Institutions Code Section14134, ranging from $1 to $5, for medical/dental services, prescription drugs and non-emergent use of the emergency room of a hospital. These co-payment provisions are not enforceable, meaning providers cannot deny the service if the person cannot pay the applicable co-payment and they are not applicable to individuals under the age of 19.

DHCS is in the process of seeking federal approval of enforceable co-payments for prescription drugs and non-emergent use of the emergency room of a hospital. For purposes of this new policy, enforceable co-payments means that the provider can deny the service to the extent the individual does not pay the co-payment. To the extent federal approval is obtained for the use of enforceable co-payments, they will be applicable to children covered under Medi-Cal.

Federal Medicaid rules require that total premiums and cost sharing may not exceed five percent of the family income for a time period specified by the State.
DHCS will work to ensure that transitioning families with incomes above 150 FPL, who will be subject to premiums, will not have cost sharing provisions that exceed the five percent threshold.

In planning ahead for the federal approval of co-payments, DHCS will seek stakeholder input to develop a methodology for tracking the five percent monthly cap without requiring beneficiary involvement. A potential premium/co-payment tracking process could be developed in coordination with MAXIMUS and DHCS' fiscal intermediary to ensure the five percent threshold is not exceeded.

Federal Approval

The State's goal is to receive timely federal approval from CMS in order to begin the transition of children in Phase 1, Part A, on January 1, 2013. AB 1494 requires that the State obtain federal approval prior to the start of the transition. The State regularly communicates with CMS—weekly technical assistance calls and bi-weekly transition calls—on the process for obtaining federal approval.

Since the release of the Strategic Plan/Phase 1 Implementation Plan, DHCS has received further guidance from their federal partners at CMS regarding the mode by which DHCS would seek federal approval for the transition. In order to secure enhanced federal funding for Medi-Cal primary care providers January 1, 2013, to December 31, 2014, and to ensure no violations of Medicaid rules pertaining to comparability, DHCS has to seek federal approval for the transition through an amendment to its existing Section 1115 Waiver, California Bridge to Reform Demonstration (11-W-00193/9).

CMS has requested that DHCS to simultaneously submit the Section 1115 Waiver Amendment and a Title XIX State Plan Amendment (SPA), which is necessary to add the new coverage group to the Medi-Cal program once the transition is complete. The effective date of the Waiver Amendment would be January 1, 2013, whereas the effective date of the Title XIX State Plan Amendment would be September 1, 2013, the date Phase 4 children transition to Medi-Cal. Additionally, MRMIB must submit a Title XXI State Plan Amendment, but CMS does not require its submission at the same time as the Waiver and Title XIX State Plan Amendments. The MRMIB amendment is a conformance amendment—it will conform the Title XXI State Plan to the Title XIX State Plan after the transition.

In the Section 1115 Waiver Amendment, DHCS is seeking to waive Medicaid comparability requirements and will add the targeted low-income group to the groups of Medi-Cal beneficiaries that may be enrolled in Medi-Cal managed care. DHCS needs to waive comparability in order to implement the phased in approach set out in statute; this will allow children in the same group to be covered under two different systems at the same time (e.g. When Phase 1, Part A, children transition to Medi-Cal, their counterparts in the targeted low-income group will still be covered under Healthy Families until their scheduled transition Phase). The waiver amendment and draft Title XIX SPA were submitted to CMS on October 30, 2012 and have been publicly shared with legislative staff and stakeholders. A comment period has also been provided for stakeholders on the contents of required amendments.

The State is working closely with CMS on technical assistance related to the submission of the Waiver and State Plan Amendments, network adequacy, subscriber/beneficiary notices and outreach, the development of rates, and the amendment of managed care plan contracts. Additionally, in accordance with federal requirements, DHCS released notification of the Healthy Families Transition to Medi-Cal to Tribes on August 24, 2012. Tribal entities have 30 days from receipt of the notice to provide input on the proposed SPA and Waiver changes.

Proposed Title XIX State Plan Amendments

- Provide full-scope Medi-Cal to children who are optional targeted low-income children with family incomes up to and including 200 percent of the FPL.
- Use of less restrictive income and resource methodologies to exempt all resources and disregard income at or above 200 percent of the FPL up to and including 250 percent of the FPL.
- Use of premiums for families with incomes above 150 percent of the FPL and up to and including 250 percent of the FPL (after applying the applicable income disregards).
- Use of the most current eligibility determination made by MRMIB/MAXIMUS to transition the Healthy Families child to the applicable new Medi-Cal transition aid code.
- Changing the delivery system of Children's Health Insurance Program (CHIP) for those children with family incomes at and below 250 percent of the FPL (Healthy

Families in California) from that described in the CHIP Title XXI State Plan to the Medi-Cal delivery system described in the Medicaid Title XIX State Plan.

Requested Section 1115 Bridge to Reform Waiver Amendments

- Addition of the new Targeted Low Income Population as a covered group under the waiver.
- Ability to transition the children from Healthy Families to Medi-Cal in accordance with the four transition phases as outlined in statute.
- Revised Cost Neutrality
- Use of the Medi-Cal managed care and dental managed care delivery systems for the transitioned children in counties where managed care exists.